UNITED STATES DEPARTMENT OF LABOR
OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

ANDREW SIEMASZKO,	)	
Complainant,	)	
v.	)	**2003-ERA- ____**
FIRST ENERGY NUCLEAR OPERATING COMPANY,	)	
Respondent.	)	

COMPLAINT

COMES NOW, Andrew Siemaszko, through counsel, and files this complaint against his former employer, First Energy Nuclear Operating Company ("FENOC") pursuant to 42 U.S.C. § 5851, as amended, for adverse action in connection with the terms, conditions and termination of his employment as a systems plant engineer at the Davis-Besse nuclear power plant in Oak Harbor, Ohio.

Mr. Siemaszko was the lead systems engineer responsible for identifying the corrosion damage, *i.e.*, hole in the reactor vessel head in late February 2002. His discovery followed the culmination of years of work to convince Davis-Besse management to completely clean the head of the reactor vessel. After the discovery, and notwithstanding the praise management originally heaped upon him for his efforts, he was removed from his responsibilities, transferred to another assignment, then

removed from those responsibilities and eventually given the choice of being terminated or resigning.

As described below, Mr. Siemaszko was one of the few, if not the only, employees terminated for cause from employment at Davis-Besse, without other employment alternatives, in connection with the events surrounding the discovery of corrosion of the reactor vessel head in February 2002. Although he was given an opportunity to resign in lieu of termination at a September 18, 2002 meeting, he declined to do so because he believed that resigning would indicate that he was guilty of misconduct. By terminating Mr. Siemaszko, FENOC has sent a message to the rest of the Davis-Besse workforce, the community in which he lives, industry officials and regulators, that he, in part, caused the problems at Davis-Besse – instead of acknowledging that his persistence in attempting to clean the boric acid from the reactor was the sole reason that a catastrophe was avoided.

Even after Mr. Siemaszko was removed from his duties in connection with cleaning the reactor head, he continued to raise concerns about additional safety-related issues at the Davis-Besse plant. One of those issues dealt with the condition of the Reactor Coolant Pumps. In response to his insistence for testing and, if appropriate, the replacement of leaking RCP gaskets, he was removed from responsibility for that issue. Two days after presenting his strong opposition to management's handling of the issue, he was terminated. His removal from

responsibilities and termination has created the impression and belief among other employees that employees who raise concerns, or insist on repairs inconsistent with the views of management, will be removed. Indeed, in the recent release of partial results of a workplace survey of Davis-Besse employees, 90% of the employees stated that "they had heard that someone had faced retaliation."[1]

Mr. Siemaszko believes that the facts will show that his removal in late August 2002 from Latent Issue Review Team responsibilities was retaliatory for his engagement in legally protected activity; that his September 18, 2002 termination was wrongful; and that it has created a "chilling effect" among other employees. He seeks reinstatement to a position of the same or similar responsibilities, back pay and compensatory damages, as well as attorney's fees and expenses in connection with this action.

I. BACKGROUND

[1] Cleveland Plain Dealer, February 12, 2003.

Mr. Siemaszko began employment at Davis-Besse on July 6, 1999 as a Lead Nuclear Engineer. In that position he had significant responsibilities for, among other things, the Reactor Coolant System (RCS). He was not provided any briefings by his management associated with the RCS head/CRDM leakage condition, first identified in the 1990s. He was not provided any briefing on the long-delayed modifications which had been initiated in response to the concerns of his predecessors.[2]

5. Leaking Control Drives and Boric Acid on Reactor Head

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[2] **In fact there had been three delayed or ignored attempts made by Plant Engineering and Design Engineering to address the concerns associated with the boric acid issue. The first attempt was made in 1990, through Modification 90-0012, which proposed to provide access holes in the service structure to aid in the cleaning and inspection of the CRD nozzles. This was canceled in 1993 without any work being done. A second attempt was made in 1994, through Modification 94-0025, which was held open without work until ultimately being canceled in late 2001 or early 2002. Finally, Mr. Siemaszko issued EWR 01-0378-00 on August 30, 2001, which was not implemented either.**

As Mr. Siemaszko was becoming familiar with the issues needing attention, he discovered that boric acid had been left on the top of the reactor head since at least 1996.[3] **In addition, he found that the D-10 CRDM Drive was found leaking during the 1998 outage and left to leak through Cycle 12. In response to this finding, he began activities that would enable him to remove the boric acid, including attempting to convince management to implement the long-delayed Modification 94-0025, that would have provided access to the reactor head for boric acid cleaning purposes. The existence of boric acid on the reactor head in 1998 seems to have been missed by the Nuclear Regulatory Commission ("NRC"), which knew or should have known, as a result of the pictures of the reactor head in 1998 and 2000 that there was red rust type discharge coming through the weep holes.**

In 1999, plant engineering management rejected Mr. Siemaszko's recommendations to add access holes, claiming that there was insufficient time to prepare the work package and meet the outage schedule. No technical evaluation was performed on the deferral; instead, an economic decision was apparently made without engineering analysis of the risk. Mr. Siemaszko was forced to perform manual cleaning of the

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[3] **The discovery of boric acid on the reactor vessel head was made through viewing the 1996 and 1998 VHS tapes of the reactor head, the April 18, 1998 PCAQR-0649 plant condition adverse to quality report and the April 17, 1998 letter from Ed Chimahusky to Outage Management. All of these documents demonstrated to him that boric acid had been found and left on the reactor vessel head for future cleanup.**

boric acid without appropriate equipment, a sufficient budget or the completion of necessary preventive maintenance. If access holes had been provided, and the boric acid had been completely removed in 2000, the cracked nozzle leading to the corrosion in 2002 would most likely have been discovered at that time.

Nonetheless, Mr. Siemaszko continued to prepare for Refueling Outage 12, working within the limitations he was given. He also attended a ten-week course on the plant systems and process. He became more familiar with the requirements of Generic Letter 88-05, through which the NRC had required that Davis-Besse provide assurance that a program had been developed and implemented with systematic measures to ensure that boric acid corrosion did not lead to degradation of the reactor coolant pressure boundary components. He also discovered that, in fact, there were insufficient preventive maintenance requirements or procedures to fully meet the intent and requirements of the NRC's Generic Letter. Twelve years after the Generic Letter was issued, Mr. Siemaszko discovered that there were no systematic measures or mandatory requirements to ensure boric acid corrosion did not affect the Davis-Besse reactor vessel head integrity.[4]

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[4] **The Boric Acid Corrosion Control procedure, NG-EN 0034 Rev.2, was not an adequate procedure to meet the intent of Generic Letter 88-05 because it contained a "loophole" (Step 2.3) that swallowed the intent of the rule, and was not implemented consistently, in fact, not at all in 1996 or 1998.**

Without a systematic preventive maintenance program or adequate procedures to pro-actively address the buildup of boric acid, Mr. Siemaszko was left with use of the Condition Report system as the only available tool to force management to actually clean the reactor head of boric acid deposits. Condition Reports 2000-0781 and 2000-0782 were issued on the first day of the outage, April 6, 2000. A review of the condition reports by FENOC management and the NRC, coupled with the knowledge of the 1998 photographs, should have convinced management to take immediate and aggressive action to address the conditions – just as Mr. Siemaszko recommended.

6. CR 2000-0782

CR 2000-0782 was issued on February 6, 2000 by Peter Mainhardt, the night shift engineer on duty when the Reactor Head became available for inspection for the first time during 12 Refueling Outage in February 2000. At that time, the head was still attached to the Reactor Vessel located in the Refueling Canal. In order to take pictures, the insulation was removed from the reactor head, examination was performed, pictures were taken and Decontamination personnel used water to clean the deposits of boric acid from the flange. This was done to enable un-tightening of the reactor studs to separate the head from the reactor body. There is always a very short window of opportunity when this activity can take place and pictures must be taken quickly. This activity of decontaminating (cleaning) is considered a critical path activity. The pictures showed red rust streaming from the weep holes, and were attached to the CR identifying the condition. The boric acid seen on the picture was removed quickly.

The CRs issued at night are discussed at the turnover meetings every morning and it is customary that the NRC inspector is present for morning turnovers during outages, and is familiar with the CRs that are issued. This would be particularly true for this outage because of the known degradation of the reactor head.

A review of CR 2002-0782 indicates that the Control Room Shift Supervisor accepted the CR, acknowledging that immediate action needed to be taken about the identified condition. The CR, as written, contained a "mode restraint"; that is, a mandatory hold point that would have and should have resulted in actions being taken to determine the extent of the problem before the plant was permitted to return to the service. To the best of his recollection and belief, Mr. Siemaszko was unaware of the CR Action Item.

The CR should have then been assigned the priority that would have required immediate repair. The CR, as originally written, had a Mode 4 Restraint. A mode restraint is an administrative tool that prohibits increasing the temperature in the reactor. The Mode 4 Restraint was never answered because it was removed three weeks later, on April 27, 2000, without Mr. Siemaszko's knowledge. Mr. Siemaszko then responded to the CR, without the knowledge that a Mode Restraint had been lifted.

Mr. Siemaszko submitted his response on April 14, 2000, and it was accepted on April 27, 2000. Unbeknownst to him, the Mode Restraint was also lifted on April 27, 2000. Mr. Siemaszko does not know whether the NRC was consulted about this critical action.[5] Given the

[5] Mr. Siemaszko points out that the 2000 "red photo" does not really differ from a 1998 photo, referred to as the "white photo". (See attached photo). The picture made in 1998 is of the same sort showing the flow of boric acid from the weep holes. The NRC should have observed that picture as well. The picture is much lighter, but if darkened it would show rust flowing from the weep holes. The comparison of the NRC's involvement is notable. The lack of NRC involvement in 1998 is even greater than during 2000. In 1998, rusty lava-like flow was

information known through CR-782, the agency should have been involved in that decision. As it turned out, Mr. Siemaszko was not advised of either the issuance or removal of the Mode Restraint, and he commenced his cleaning activities on April 28, 2000. It should be noted that on April 10, 2000, Mr. Siemaszko attempted to make a video of the deposits, but could not do so because the boric acid buildup was blocking the entrance to 25% of the weep holes. Four additional attempts at manual cleaning were attempted over the following six days, all of which failed to complete the cleaning activity.

7. Condition Report 2000-1037

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photographed — see "white photo". In 2000, rusty lava-like flow was photographed — see "red photo". In 1998, the VHS video was produced to show 25% of the reactor head covered with boron. In 2000, a VHS video was produced to show 25% of the reactor head covered with boron. In 1998, CRDM flange D10 was leaking, but no **repair was performed**. D10 was permitted to leak for two more years. In 2000, CRDM flange D10 was leaking, all of the leaking **flanges were repaired, including** D10 and four other flanges. In 1998, 25% of head was left unclean. An evaluation was made that it was all right to leave boron as it was. **No plans were made to clean the head in 2000.** In 2000, 25% of head was left unclean, and management again postponed the remaining cleaning till 2002. Finally, plans were made to complete cleaning.

In other words, the information available in 2000 was also available in 1998. The NRC did not address the concerns either in 1998 or in 2000. The lava-like flow in 2000 was really no different from the information known to FENOC in 1998, as the NRC either knew or should have known in 1998.

If the NRC had done its job, Mr. Siemaszko believes he would have been permitted to do his. The NRC Region III office and resident inspectors provided no real oversight at Davis-Besse. Either they were not actively involved in reviewing the issues, or they did not understand what they were seeing. Mr. Siemaszko's previous experience in Region IV was much different than his experience at Davis-Besse. In Region IV, the resident inspector was actively involved in day-to-day activities at the plant. He reviewed CRs, and other documents pertinent to the plant status. He also issued monthly reports to the Region of his concerns and findings. In Region III, there was just silence.

Unable to succeed with complete boric acid removal and not able to convince upper management to use other methods, *i.e.*, a different type of water spray, to clean the head, Mr. Siemaszko issued an additional Condition Report (2000-1037) on April 18, 2000.[6] **The CR identified boric acid deposits between the CRD and the head, and recommended use of water to clean the deposits. (Originally the Design Engineers rejected use of water for cleaning the boric acid, but Mr. Siemaszko investigated the concern and found that, with proper precautions, use of water was acceptable for cleaning.)**

On April 21, 2000, a scope change request was issued and accepted to add the cleaning activity to the outage scope. Work Order 1846 was also issued for the construction and placement of the scaffolding and support work necessary to perform the cleanup. The support and preparation work was completed on or before April 25 and accepted on April 27, 2000. CR 2000-0782 and CR 2000-1037 were both closed and removed both from the Mode Restraint List on the basis that the boron on CRD nozzles on the reactor vessel head had already been evaluated, and would be cleaned of all boron deposits following completion of the CRD flange repairs by Framatome. Then the clean up began.

D. Cleaning the Head of the Reactor with Water and Crow Bars

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[6] **It should be noted that originally the CR had a mode restraint included, but that mode restraint was removed by David Geisen on April 27, 2000. Mr. Siemaszko was unaware that a mode restraint had been lifted.**

The actual cleaning of the reactor head was scheduled to be completed under a Radiological Work Permit (RWP), issued by the Health Physics organization. The cleaning started on the morning of April 28, 2000 and proceeded under Mr. Siemaszko's direction and control. The work lasted all day and had to be terminated for the day due to the workers reaching maximum allowable hours of work per 24-hour shift. The cleaning work was observable by the entire workforce through closed circuit streaming video being used during the operation. The danger of this operation to the workers was substantial; at times the workers who were cleaning the boric acid were required to actually expose themselves to the "shine" from the radiological source. At times, the workers used a crowbar to attempt to break up the hardened boric acid deposits.

The cleanup was an exhausting activity which was not very successful. After twelve hours of cleaning, a decision was made to alter the length and the shape of the spray nozzle. The cleaning with the new tool was to take place on the next day. At the end of the shift, Mr. Siemaszko briefed outage central management that more cleaning was required, because the boric acid deposits were "lava like" and could not be removed with the existing methods. There was no discussion about stopping the cleaning activity. Mr. Siemaszko left work on that day with the full knowledge and belief that the cleaning project would continue until completion.

Mr. Siemaszko believes that if he had been provided a few more hours of cleaning time with the new nozzle spray, he would have found the hole in the reactor head.

E. The Mystery of the Midnight Shift Breakdown

When Mr. Siemaszko returned to the site the next morning to continue with the cleaning operation, he was shocked to find that the scaffolding and all of his cleaning equipment had been removed during the night. He went to his management and outage management immediately to determine why the cleanup had been aborted. He was told by his supervisor that Condition Report 2000-1037 must be closed prior to the restart for Cycle 13, and therefore the cleaning activity did not have to be finished during this RFO, but could be completed during the next. He was told that he should be satisfied with how much he had been able to accomplish. Mr. Siemaszko did not agree with this decision, and made his position known to a number of managers and employees. He never made a representation that the project was finished.

Meanwhile, during the night, besides removing the scaffolding, site management had written and published the *Outage Insider* for 12 RFO - Day 29 and featured a detailed discussion about the reactor head cleaning project from the day before. This publication was the beginning of management's deception to the workforce and later to the public and the NRC. It was not crafted or written by Mr. Siemaszko, but is based on interviews conducted with him prior to the beginning of the cleaning –

when he assumed that he would be permitted to clean the entire head. The *Insider* incorrectly stated the condition of the cleanup work that had been accomplished the previous night:

> **The Reactor Head was successfully cleaned yesterday, thanks to Andrew's efforts, as well as those of the Radiation Protection Technicians. This is the first time in Davis-Besse's history that the Reactor head has been cleaned. Andrew was a salesman to management, Radiation Protection, and Outage Management, because he felt so strongly about the need to successfully clean the Reactor Head. Congratulations, Andrew on your perseverance, and willingness to effectively deal with the challenges that were presented.**

It was then obvious to Mr. Siemaszko that the decision to limit the boric acid cleaning activities to one day, regardless of the amount of work accomplished or the status of the cleaning operation during that day, had been made before the work had even begun. Finished or not, management had given Mr. Siemaszko only one day to remove between four and five years of boric acid accumulation. All of the personnel involved in the cleaning operation, including outage management, radiation protection, plant engineering and the managers were aware that substantial boric acid deposits remained on the reactor vessel head. The NRC either knew or

should have known the condition of the reactor head either from CR-00782 and its attached pictures, its attendance at outage meetings, or its general observation of the outage activities and discussions.

Management understood and acknowledged that Mr. Siemaszko was not satisfied with the status of the boric acid cleaning efforts, and that he wanted to continue with the cleaning activities the next day. In an effort to placate him, he was told by management that he would get all the help, equipment, resources and support to finish the removal of the boric acid during Refueling Outage13. He was told that it was now too late to finish the cleaning activities in 2000, and that he had done much more than his predecessors on this issue, that he should be proud and satisfied with his going out of his way to perform the cleaning of the reactor vessel head.[7]

[7] **Management's promises were, in fact, later fulfilled by the purchase of expensive camera equipment and by providing a contract to an expert company to actually finish the cleanup on the reactor head, as promised.**

F. Discovery of the Reactor Head Damage

To Mr. Siemaszko's credit and resolve, even before 13 RFO he was still actively trying to find the source of the boric acid leaks. He postulated nine possible sources for the leak. He recommended several other tests, walkdowns and power entry to containment to determine the source of the boric acid leaks. As a result of his initiative, he eliminated possible sources down to three areas. He then recommended several more tests, walkdowns and power entry to containment to determine the sources of the boric acid leak. For the remaining three areas, he requested the resources, time, and permission to execute three tests. Management denied his requests.

In addition to his attempts to obtain resources to determine the source of the leaks, Mr. Siemaszko also recommended replacing the reactor head with an available head from the unused Midland, Michigan reactor. He obtained a quote from TechLink, Inc., on August 2, 2001, to purchase the replacement reactor head for 3.5 million dollars, plus an additional 3 million for qualification of the head. (This was done in the wake of increasing knowledge about nozzle cracking concerns throughout the industry and future needs for 100% ultrasonic testing of the head. He estimated that the cost of replacing the head would be less than the examination cost during the next several years.) Management rejected his suggestion.[8]

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[8] FENOC has now, in fact, purchased the Midland reactor head, and estimated the cost of

Finally, during 13 RFO, Mr. Siemaszko was able to finish the work of cleaning the head of the reactor he had been trying to get done since his arrival at Davis-Besse. Finally, after years of an uphill battle to clean the reactor head, the contractor broke through the boric acid. To his horror, Mr. Siemaszko soon realized the source of the leak and its consequences – a virtual hole in the reactor head.

Mr. Siemaszko's actions were well-known throughout the Engineering Department and the workforce. His activities demonstrated the type of commitment to safety that should have been prevalent at the site. Given that there was no management support for the activity, he had to cajole and plead and bargain to get the tools and resources to finish the project. At times, it appeared he was the only one who cared about it. However, instead of being praised and thanked for demonstrating the perseverance to get the job done in the face of management pressure to defer and delay the work, he immediately became the subject of investigation and scrutiny. He was removed from responsibility for the work and given other tasks. He was then removed from those tasks. The workforce observed all of these actions and events, and questioned him personally about this bizarre development. He had no answers.

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purchase and replacement to be between $55 million and $75 million. *Port Clinton News Herald*, September 19, 2002.

G. Transfer to Latent Issue Review Team

Immediately upon his discovery of the hole in the reactor, Mr. Siemaszko was removed from any responsibility for the boric acid removal activities. He was transferred to work on the Latent Issue Review team. In that capacity, he continued to identify issues of safety concern and non-compliance, and became even more strident about pursuit of those latent issues and concerns.

The Latent Issue Review (LIR) effort was an aspect of the restart program. Management established new standards of excellence that were supposed to be implemented at Davis-Besse. According to management, the new standard was based on non-tolerance of degraded equipment and a commitment to identifying all latent issues, such as the boric acid situation, which could contribute to an accident.[9] LIR Procedure EN-DP-01505 was implemented at Davis-Besse in 2002. Paragraph 5.8.1 requires that the responsible RCS System Engineer ensure overall system health and performance.

Systems engineers at Davis-Besse were trained prior to the LIR procedure implementation, including being advised that they would be held personally responsible for the system readiness and, if necessary, be required to testify in front of the Plant Restart Review Board and/or the NRC. Mr. Siemaszko was identified in the draft of the procedure as an LIR leader for Reactor Coolant System (RCS).

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[9] **Latent issues, unlike active errors, are those that usually pose the greatest risks in disasters. They are the unseen, and often overlooked, decisions of managers, designers and engineers. As stated in Safety Line Institute's publication on Latent Errors, "[i]t should be clearly understood that the way to prevent such disasters is to ensure that there is an adequate safety culture, to minimize latent errors and in particular to ensure that management decisions put safety first."**

H. The Reactor Coolant Pump Gasket Leakage Concern

One of the latent issues was the operability of the Reactor Coolant Pumps and inner/outer gasket leakage. Like the boric acid on the reactor head, the gasket leaks have been known to FENOC management for many years. Previous Reactor Coolant System engineers had also brought the gasket replacement issues to management's attention. RCP gasket leakage issues were broadly discussed in Generic Letter 88-05, in which the NRC recommended that leaking RCPs were considered degraded components. Generic Letter 88-05 also provided an example of what a leaking gasket could lead to:

> At Fort Calhoun, seven reactor coolant pumps were reduced by boric acid corrosion from a nominal 3/5 inches to between 1.0 and 1.5 inches. (IE Information Notice 80-27.)

Generic Letter 88-05 stated further that:

> In June 1981, the Institute of Nuclear Power Operations issued a report discussing the effect of low level leakage from the gasket of a reactor coolant pump and concluded that significant corrosion of the pump studs could occur during all modes of operation.

All four Reactor Coolant Pumps at Davis-Besse have a longstanding history of gasket leakage resulting in deposits of boric acid on the carbon steel-casing studs. This was documented in CR 2002-01523. In addition, all four pumps have studs that are overstressed (elongated) up to 0.026 of an inch. This is as much as 0.004" in some cases over the specified limit set by the vendor. In 1998, all four RCP were tested and found to leak by its inner gaskets; in 2000, three were found leaking; and in 2002, only two pumps (RCP 1-1 and 1-2) were tested. Both leaked past the inner gaskets. RCP 2-1 and 2-2 were not tested.

The inner gasket drain lines are not equipped with flow measuring devices. Isolation valves (RC304 for RCP 1-1) located in seismic Class 2

lines (3/4 "CCB-22 for RCP 1-1, P&ID M-040D Rev. 12) have to be closed during power operations to contain RCS leak and to prevent it from draining to the Normal Sump located in the Containment Building. Isolation valves cannot be left open because leak-off to Normal Sump would have to be considered as an unidentified RCS leak. Restarting the plant with known unidentified RCS leaks was, and remains, a serious safety concern to Mr. Siemaszko. This is particularly true because, although not a direct system integrity component, the RCP functions as one of the critical compensatory measures relied upon to protect public health and safety in the event of a Loss of Coolant Accident (LOCA).

Flowserve, the RCP vendor, reviewed the situation and recommended that the leak-off isolation valve should be closed once the inner gasket is found to be leaking and gaskets replaced at the next available window of opportunity. Flowserve also provided a recommendation in a July 2002 letter to the company stating:

> **The specification for allowable leakage is zero. Any leakage will require pump disassembly and gasket replacement to restore joint tightness.**

On July 10, 2002, Mr. Siemaszko issued a letter to his supervisor, John Cunnings, and RCP Project Manager Geisen, entitled "RCS Extent of condition recommendations." He recommended replacement of inner/outer gaskets/seals for all four Reactor Coolant Pumps. His recommendations were based on the research and written recommendations from Flowserve. Mr. Siemaszko also verbally informed

his supervisor that he would not sign the Latent Issues Review report unless all four Reactor Coolant Pumps underwent inner/outer gasket replacement.

On August 8, 2002 CR 02-03668 was issued, raising the concern that all four Reactor Coolant Pump gaskets should be replaced in order to ensure Davis-Besse's safe operation. On August 9, 2002, Cunnings and temporary Equipment Reliability supervisor, Jim Barron, issued NPE-02-00227, entitled "Reactor Coolant Pump Issues," to the Plant Engineering Manager, also recommending replacement of gaskets on all four pumps.

Some time between July 10, 2002 and August 20, 2002, Mr. Siemaszko began to suspect that management was no longer utilizing him as the RCS Team Leader. He attempted to determine if these suspicions were valid, but was unable to do so. However, during a meeting on or about August 23, 2002, Mr. Siemaszko was told that he no longer had to attend the LIR meetings, training or project development activities. Although there was no official letter describing the removal of his duties and responsibilities, he saw a document designating another engineer as the RCS System Engineer on the LIR team. Then, at a meeting on or about August 23, 2002, Mr. Siemaszko was advised during a meeting, in front of the entire room of engineers, that he no longer needed to attend the LIR meetings. At that point Mr. Siemaszko realized he had been again removed from responsibilities.

The RCP controversy came to a head at a meeting on September 16, 2002 in the office of the Director, Nuclear Engineering, Jim Powers, Jr. The meeting was to discuss the RCP gasket replacement issues and to agree on the scope of the project. During the meeting, Mr. Siemaszko confronted Mr. Powers with the issue of the partial air pressure drop test, and objected to and challenged management's decision to reject and ignore the recommendations of the expert contractor and the system engineers involved in the RCP gasket review. However, the meeting concluded with Mr. Powers and Mike Stevens, a newly-appointed Director of Work Management, recommending replacement of gaskets on only two RCP pumps.

Two days later, on September 18, 2002, Mr. Siemaszko was given the choice of resigning or being terminated, allegedly for his involvement in the events surrounding the cleaning of the reactor head.

I. The Importance of Repairing the RCP Pumps Prior to Restart

It should be noted that repairs of all four RCP pumps would have required significant time and money investment. The repairs would have extended through the December 7, 2002 deadline then set by FENOC as a goal for Davis-Besse restart. When confronted with the engineering/vendor recommendations of RCP pumps gaskets replacement, Mr. Myers rejected all recommendations and immediately reduced the scope of work to two RCP pumps, 1-1 and 1-2, on the West D-Ring. Mr. Myers did not change his position on the issue during the next three weeks of negotiations between Engineering and Management. He did not provide any basis for his decision. Mr. Stevens simply explained that the company would work on two pumps first, and later during mid-cycle outage, would see if the gaskets were still leaking and then work on the remaining two gaskets.

The access to the RCP motors in the West D-ring is fairly easy and requires removal of only a few pipe supports and structural beams. The remaining two RCP pumps, 2-1 and 2-2, are located in the East D-ring and are significantly harder to access. East D-ring contains Pressurizer and Quench Tank systems. Many components would have to be removed from the East D-ring prior to the work on the pumps.

In order to assist in making a determination on the condition of the gaskets, Mr. Geisen had asked to perform air pressure drop tests on all four RCP gaskets. The air pressure drop test consists of pressurizing the inner/outer gasket space to 50 PSIG at the ambient temperature and observing the pressure drop over a given period of time (approximately 5 minutes). This test is to identify any gross gasket leakage that could be observed between the inner gasket space and the drained RCS piping system or the Containment atmosphere. If the pressure loss was observed during the performance of the test, it would be impossible to distinguish which (inner or outer) gasket is leaking. Mr. Geisen was only permitted to perform the test on RCP 1-1 and

1-2. Both pumps were already scheduled for inner/outer gasket replacement, and thus a failed test would not have impacted the work scope.

This was not true with respect to RCP 2-1 and 2-2, where a failed test would require evaluation and possible change of work scope. Tests performed on RCP 1-1 and 1-2 resulted in no pressure loss. Mr. Siemaszko challenged Mr. Geisen numerous times to perform the same tests for the remaining RCP 2-1 and 2-2 pumps. Mr. Geisen told Mr. Siemaszko that he had been directed by his superiors not to perform the test on RCP 2-1 and 2-2, based on the fact that the test would be performed only on the pumps scheduled for gasket replacement and plans to replace inner/outer gasket on RCP 2-1 and 2-2 during the mid cycle outage or during the 14 RFO. The fate of RCP gaskets replacement program is currently left in the hands of one contractor who recommended gasket replacement and First Energy Managers.

Upon information and belief, in December of 2002, an RCS LIR report was issued with the following recommendations:[10]

- RCS system <u>is not</u> ready for the restart;
- RC2 should be replaced;

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[10] As of January, 2003, Davis-Besse management had completed gasket replacement on only two of the four Reactor Coolant Pumps. There are apparently no plans to repair the two remaining Reactor Coolant Pumps prior to restart. Instead, in early March of 2003, FENOC is preparing to pressurize RCS to a full pressure and temperature and observe Reactor Coolant Pumps for leakage for seven days. If the pumps do not leak through the outer gasket, an attempt may be made to postpone the repairs until a later date. This does not demonstrate conservative decision making, as committed to by the "new" Davis-Besse management.

In addition, during the shaft/impeller refurbishment on RCP 1-1, cracks were discovered in the shaft. Spare Crystal River shaft was purchased to replace the degraded one at Davis-Besse. The shaft cracking found on RCP 1-1 indicates that a generic issue may be applicable to all Reactor Coolant Pumps at Davis-Besse. Three out of four shafts and impellers are of the same vintage. This further strengthens the recommendation to inspect and refurbish RCP 2-1 and 2-2 shafts/impellers and at the same time to replace inner/outer gaskets.

- **All four** inner/outer RCP pump gaskets should be replaced prior to restart.

Nonetheless, despite the recommendations of all the above-noted engineers, only two of the four RCP pump gaskets are being repaired

II. MR. SIEMASZKO'S REMOVAL FROM RCP DUTIES AND HIS TERMINATION WERE MOTIVATED, AT LEAST IN PART, BY HIS ENGAGEMENT IN LEGALLY PROTECTED ACTIVITIES

Mr. Siemaszko can easily establish a *prima facie* case of retaliatory discharge. He engaged in legally protected activities, those activities were known to the decision makers responsible for his termination, and there is a causal connection between his protected activities and the basis for his termination.

A. Mr. Siemaszko Engaged in Legally Protected Activities

Mr. Siemaszko engaged in legally protected activities throughout his employment at Davis-Besse. His internal protected activities began almost immediately after he began employment with FENOC. FENOC itself acknowledged that as far back as the 12 RFO, Mr. Siemaszko recognized the dilemma of boric acid buildup on the reactor head and made it a personal goal to get it removed. In order to convince management to do so, he had to expend considerable effort in attempting to revive a longstanding, *i.e.*, since 1994, proposed work package. Between the 12 RFO and the 13 RFO, he continued to press the issue of cleaning the head of the reactor. After the discovery of the corrosion, Mr. Siemaszko was involved in numerous internal and external protected activities through interviews and discussions with the NRC.

Finally, during the two months prior to his termination, Mr. Siemaszko again found himself engaged in internal protected activities trying to convince FENOC management to take a conservative engineering approach to a serious problem with the Reactor Coolant Pumps.

B. Mr. Siemaszko's Protected Activities Were Well-Known to the Decision Makers

Two days after the RCP issues came to a head, in a September 16, 2002 meeting with James Powers, Director of Nuclear Engineering, Mike Stevens, Director of Work Management, John Cunnings, Steve Roe, David Geisen, Curtis Dew, and representative from the vendor, Flowserve, Mr. Siemaszko was fired.

There can be no credible dispute that the decision makers responsible for the decision to remove Mr. Siemaszko from his position on the Latent Issue Review Team, and later to terminate him, had knowledge of his internal and external protected activities.

C. Mr. Siemaszko Suffered a Variety of Adverse Actions

As outlined in the Background section of this complaint, Mr. Siemaszko was first removed from his responsibilities on the reactor head cleaning project upon discovery of the hole in the reactor. He is not contesting that decision here, since he understands the legitimate need of the company to investigate every aspect of the incident.

However, after being reassigned to the LIR team, Mr. Siemaszko was again pressured and harassed into abandoning prudent safety concerns. He was "removed" from his leadership responsibilities on the LIR after insisting that the RCP issues be addressed prior to restart. Finally, on September 18, 2002, he was given an opportunity to resign or be terminated.

D. There Is a Connection Between the Protected Activity and the Adverse Action

The circumstantial evidence that both adverse actions are connected is overwhelming. Using any of the standard methods of proof, from temporal proximity to disparate treatment, Mr. Siemaszko can establish that his removal from the Latent Issue Review Team and his subsequent termination was the result of management's animosity towards his engagement in legally protected activities.

E. FENOC's Alleged Legitimate Business Reasons Do Not Withstand Scrutiny

The alleged legitimate business reasons given by FENOC for Mr. Siemaszko's termination do not withstand analytical scrutiny. The September 24, 2002 letter to Mr. Siemaszko states that he was terminated because his actions in connection with the Davis-Besse reactor pressure vessel head "fell below Company expectations." The two specific aspects of his performance mentioned that allegedly gave rise to the decision to terminate him dealt with his actions during the 12 RFO and in connection with his NRC cooperation and disclosures.

1. Mr. Siemaszko Did Not Mislead Anyone about the Status of the Reactor Head Cleaning Effort

When Mr. Siemaszko was terminated, management implied that they had been misled by virtue of the close-out of CR 2000-1037 and that management relied upon that misrepresentation. That is not even close to the truth. There is no question that the reactor head was not clean of boric acid on May 1, 2000, that cleaning activities were not completed, and Davis-Besse management knew it at the time. First, streaming real time video coverage played throughout the day of the cleaning on the plant's closed circuit television, revealed the cleaning activities – including workers using crowbars to try and dislodge the boric acid. Second, a copy of the post-cleaning video was provided to the Director and Manager of plant engineering. Third, Mr. Siemaszko's actions throughout the next year demonstrate that he continued to accurately describe the boric acid deposits on the reactor vessel as a problem needing attention. For example, in March 2001, he made a presentation to the Plant Engineering Review Board. During the presentation, he discussed 13 RFO issues, including the need to complete boric acid removal remaining from 12 RFO, and also requested contractor funding and assistance for the project.

On August 30, 2001, Mr. Siemaszko initiated EAR 01-0378 -00, in which he stated that "[p]revious attempts to remove these deposits performed during 12 RFO were unsuccessful. This was due to inadequate size of the access holes." Management did not react to these or any other

discussions or disclosures by Mr. Siemaszko as if this was a surprise. No CR was issued, no Stop Work initiated, no modification or amendment of the closed CR was initiated, no investigation was commenced. Indeed, nothing was done to even remotely suggest that management was under the impression that the reactor head was clean. Everyone in any position to address the situation knew it was not. Apparently, the NRC's own initial investigation of there events confirmed that there was senior management knowledge about the remaining boric acid, as discussed in the March 2002 IN 2002-11, page 3 of 5.

Another alleged reason for Mr. Siemaszko's termination was that he had allegedly "failed to satisfy the requirements of the Boric Acid Corrosion Control procedure." It is true that he did not fill out the second page of the form Boric Acid Corrosion Control Inspection Checklist, Attachment 1 to the Boric Acid Control Procedure, which would have documented his follow-up examination results.

However, the issue of Mr. Siemaszko's "technical" completion of the second page of the form is a "red herring" and further evidence of disparate treatment. First, he had not completed training on the technical aspects of filling out the form, and was not trained on these aspects until three months after the event for which he was allegedly terminated. According to the procedure NT - ST - 07044, Step 6.4.3, requires that "individuals shall complete activities as specified in each position-specific JFG prior to independently performing position specific

job activities. Individuals who have not completed the position specific job activities shall only perform these activities under the direct observation or reviewable task performance methods." It was the responsibility of Mr. Siemaszko's supervisor to ensure that all of his subordinates were trained and qualified for the tasks for which they were responsible. That did not happen in this case.

Even if Mr. Siemaszko had filled out the second page of the form, it would not have prevented the corrosion of the reactor head. The fact is that the Boric Acid Corrosion Control procedure did not control the examination of the CRD nozzles to the reactor head area. The procedure NG-EN-00324 was a generic procedure that did not have any specific mandatory requirement to ensure that adequate inspections were performed. Prior to 2001, there were no Preventive Maintenance work requirements. Qualified personnel were not utilized to perform inspections of the area. There was no site equipment capable of obtaining the resolution required to perform the inspection activities. There were no specific inspection procedures to govern the inspection activity, had it been performed. The nozzle RPV head annulus area was too obscured to detect leakage under any circumstances. Mr. Siemaszko conducted numerous follow-up examinations which are "documented" through VHS tapes and outage notes to outage management and which are available for verification and review.

2. Mr. Siemaszko's Role in Responding to the NRC Bulletin

The September 24, 2002 termination letter also states that one of the reasons Mr. Siemaszko was terminated was his role in the preparation and review of the Company's responses to NRC Bulletin 2001-01, which led to inaccurate or incomplete statements to the NRC in docketed licensing correspondence. According to the letter, Mr. Siemaszko failed to ensure that the initial response accurately described the physical restrictions on access to the head and the as-left condition following 12 RFO. He was also accused of providing inaccurate and incomplete information to the NRC orally, and in two additional licensing submittals. These accusations are untrue and a pretext to provide a scapegoat to the NRC. More importantly, Mr. Siemaszko believes these false charges were leveled at him because he was the person providing accurate information to the NRC about what happened and his disclosures were problematic for FENOC.

a. Mr. Siemaszko's Alleged Failure to Ensure that the Initial Response Accurately Described the Physical Restrictions on Access to the Head and the As-Left Condition Following 12 RFO

The NRC issued Information Bulletin 2001-01 (IB 01) on August 3, 2001. In response, FENOC issued Condition Report 01-2012 on the same day. Dale Miller of the Licensing Department requested that Andrew Siemaszko answer part of question 1.d. This query was, in relevant part, as follows:

> **All addressees are required to provide the following information . . . a description of the . . . RPV inspections (type, scope, qualification requirement, and acceptance criteria) that have been performed at your plant(s) in the past four years, and the findings. Include a description of any limitation (insulation or other impediments) to accessability of the bare metal of the RPV head for visual examinations.**

IB 01 p. 11 of 15.

Mr. Siemaszko and other engineers prepared the draft response to these specific issues and provided it to the licensing department in mid-August 2001. Mr. Siemaszko's draft response included items which FENOC neglected to include in its response to the NRC. For example, in the draft response about the 1998 11 RFO, Mr. Siemaszko made the following statements:

> **The head was cleaned by use of manual scrubber and vacuum. The head cleaning was limited by the location and opening size of the weep holes. The head was cleaned as best it could be considering the dose and the method.**

Mr. Siemaszko's statement of qualification and limitation was removed and was not included in the letter to the NRC. (September 4, 2001, Serial 2731, p. 3) Instead, the company made the following representation: "The head was cleaned by use of manual scrubber and

vacuum through the weep holes. The head was videotaped after cleaning for future reference."

This statement, after removing the qualification and limitation in the draft, creates a clear – but inaccurate – impression that the head was *completely* cleaned. That was not true, and this statement cannot be attributed to Mr. Siemaszko. (The NRC Letter Review and approval report does not have Mr. Siemaszko's signature on the sheet as agreeing to the letter. Instead, it refers to an unidentified attachment. If the attachment was the table prepared by Mr. Siemaszko as a result of the analysis of the review of the tapes, it is a misrepresentation of Mr. Siemaszko's analysis, which did not say that the "entire head was inspected.") The same apparent manipulation was done with respect to 12 RFO in 2000. Mr. Siemaszko made the statement in his draft as follows:

> **No visible evidence of nozzle leakage was detected. Majority of nozzles were inspected. The head cleaning was limited by the location and opening size of the weep holes. The head was cleaned with demineralized water as best it could be considering the dose and the method.**

The letter to the NRC, September 4, 2001 Serial 2731, did not include these limitations, but instead stated:

> **No visible evidence of nozzle leakage was detected. The RPV head area was cleaned with**

demineralized water to the greatest extent possible while maintaining the principles of ALARA (As Low As Reasonably Achievable) regarding the dose.

The licensing department again removed the qualifiers and implied that there were no obstructions to permit 100% access for inspection and cleaning.[11] In other words, the degraded condition was most likely already present during the 1996 inspection. A Condition Report was issued in 1996, setting forth a requirement for inspections in 1998 and 2000. No VHS tapes are mentioned as a tool for examination in Serial 2731. As a practical matter, it is unlikely that 100% of the reactor head was actually visible in 1996. Mr. Siemaszko never made this representation. He did not even work at Davis-Besse in 1996, so his post-review analysis of the tapes could, at best, attest to 30-50% of the nozzles on the 1996 video.

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[11] **Mr. Siemaszko's initials appear on the Review and Approval Report; however, the date of 10/17/01 is not in Mr. Siemaszko's handwriting. While FENOC's position is that he had a duty to review all of the drafts after he provided his initial written input to ensure that the company's final reply was accurate, there was no attempt made to confirm that was done. In fact, Mr. Siemaszko does not recall seeing or reviewing the version of the letter containing the language stated above. If he saw it, he did not recognize the significance of the difference in language until much later. In any event, he was not the author or person responsible for the communication with the NRC, and at that point the responsibility for those communications was being controlled by management.**

b. Mr. Siemaszko was also accused of providing inaccurate and incomplete information to the NRC orally and in two additional licensing submittals

Mr. Siemaszko attended only one meeting at the NRC headquarters in Rockville, Maryland, on November 14, 2001. (Davis-Besse Log Entry 5880) The purpose of the meeting was for Davis-Besse to supplement its response to the IB, respond to NRC Staff questions, update the PRA, and seek permission to defer the inspection of boric acid deposits on the reactor vessel head to 13 RFO. Prior to the meeting, Mr. Siemaszko was advised by his Director and the Manager of Design Basis as to the objective of the meeting. He was told that he was to explain to the NRC that he had seen the nozzle from various angles, that the video/pictures were representative of what he had seen, and that the issue was to discuss "popcorn like" deposits only.

During the meeting, Mr. Siemaszko made a very short (approximately one minute) presentation about his visual review of the videotapes of 1996, 1998 and 2000. He stated his reasoning for not videotaping 75% of the clean surface of the head, since there was no obstruction he could (and did) visually verify that there was no leakage in that area. In addition, he advised the NRC staff that he had converted the tapes to CD format and made pictures from the CD. He told the NRC Staff he had visually observed each viewable nozzle to a greater extent than was represented on the picture. He stated that he had not seen any "popcorn like" deposits on the nozzles that could be seen. He advised the

Staff that the viewing of the tapes took weeks and that there was more information than he had captured on the photographs. The tapes were made available to the NRC during a November 8 visit by David Geisen. Mr. Siemaszko was not present for the November 8 meetings and cannot attest to what was actually presented to the NRC. However, the tapes reveal mounds of boric acid obstructing the nozzles on the inaccessible 25% of the reactor head. It would not be possible to view the videotapes and not observe the substantial amount of boric acid on the inaccessible portion of the reactor vessel head. Davis-Besse management had possession of the tapes prior to the November 8-9 meetings and, upon information and belief, reviewed the tapes prior to the meeting with the NRC. [12]

It is not clear what additional NRC submittals are being referred to in the termination letter. However, Mr. Siemaszko participated in only one additional NRC submittal that he recalls, *i.e.*, the supplemental Response to NRC Bulletin 2001-01, dated October 17, 2001, Serial 2735. Like the earlier submittal, the letter provides a misleading picture of the facts. This picture was created by Davis-Besse management and the licensing department, not Mr. Siemaszko. For example, in Serial 2735, Davis-Besse

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[12] During the November 14, 2001 meeting, Office of Nuclear Reactor Regulation ("NRR") staff members requested an immediate shutdown of the Davis-Besse plant due to the suspected Primary Boundary leakage. The staff stated, in effect, "you know that you are operating with a primary boundary leakage and you should shut down and find that leak." FENOC's response was that NRR had an obligation to prove its accusation was true prior to FENOC taking any such drastic action, or litigation against the agency would ensue.

states that in May 1996, the RPV head was inspected, and that no leakage was identified (p. 1 of 5). It further states on page 2 that there was a "whole head visual inspection. . ." in 1996. Neither of these statements are based on anything provided to Davis-Besse management by Mr. Siemaszko. (As noted above, Mr. Siemaszko's initials appear on the Review and Approval sheet, but the date next to those initials is not in his handwriting, and he is unclear about what version of the document he actually saw.)

Mr. Siemaszko was in possession of a historical videotape of the 1996 inspection, which depicted only approximately 30-50% of the nozzle population. There are other similar misleading and inaccurate statements throughout the NRC letters (and made at the NRC meetings), but Mr. Siemaszko did not participate in the drafting or editing of this document.[13] More importantly, the videotapes of the actual condition of the reactor vessel head were provided to Davis-Besse management, and

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[13] **In the October 30, 2001 letter, Serial 2744, Davis-Besse made the statement that "[t]he inspections performed during the 10th, 11th and 12th Refueling Outages . . . consisted of a whole head inspection of the RPV head in accordance with DBNPS Boric Acid Control Program pursuant to Generic Letter 88-05. . . ." This was not true. In a November 1, 2001 letter, Serial 2745, a statement is made that during the 10 RFO in the Spring of 1996, ". . . the entire head was visible so 100% of the CRDM nozzles were inspected, with the exception of four nozzles in the center of the head." Of course, as we now know, one of those nozzles was G-9, and has turned out to have caused damage to the reactor head.**

subsequently to the NRC. Thus, all had access to the best available information without need for any interpretations.

III. "CHILLING EFFECT" ISSUES

As is obvious from the above stated facts and circumstances, Mr. Siemaszko performed as a conscientious and dedicated FENOC employee for three years. He advocated for cleaning the reactor vessel head for the first time in Davis-Besse's history. He developed a plan for accomplishing the work and implemented it. But for the midnight interference by management during 12 RFO, he would have been prepared to complete the job before the outage was over.

FENOC's treatment of Mr. Siemaszko has caused or contributed to a "chilling effect" at Davis-Besse. During 12 RFO, Mr. Siemaszko was congratulated for challenging management to do what had never been done before, *i.e.*, clean the head of the reactor. He was acknowledged by his management and peers for implementing the program to do so. Then, before he could even finish the job, it was canceled out from under him in a mysterious midnight shift activity. Upon his return to work the next day, he faced a Hobson's choice of either agreeing to leave the boric acid on the head of the reactor and be assured it would be removed during 13 RFO, or complain about the cancellation and insist on completion without the necessary technical basis to do so. He feared losing his job, position, and stature if he demanded completion and delayed the restart of the

plant.[14] If he waited until the next outage, he recognized there was still an unknown risk of a leak, but one that neither he nor anyone else had reason to believe was in existence. He chose to go along with the desires of management and wait until the next outage to finish the job. He now knows, as indeed we all now do, that as he waited and planned for the next outage, the reactor head was being corroded away by an unidentified leak from a CRD nozzle not visible under the boric acid.

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[14] **On April 17, 1998 Ed Chimahusky had issued a memo to Outage Management justifying leaving boric acid on the reactor head, and stated that "Although the powdery boric acid noted on the head insulation could migrate to the reactor head, past reviews by Framatome indicated that this dry boric acid from the drives would not pose a corrosion concern to the head." In PCAQR 1998-0649, Mr. Chimahusky stated "Additionally, B&W documentation discussing CRDM nozzle cracking further stated that boron deposits on the head caused by leaking CRDM flanges would not result in head corrosion." Mr. Siemaszko had no technical basis to disagree with Mr. Chimahusky. (It should be noted that even though no supporting documentation was ever produced by Mr. Chimahusky to support his representations, he is now working in the Quality Control section of Davis-Besse with no apparent discipline for his misrepresentations and lack of judgment.)**

IV. REQUEST FOR REMEDIES

Mr. Siemaszko has lost far more than a job as a result of this termination. He is a proud man, who came to this country in 1978 with a professional degree, but had to rebuild his reputation and career from scratch. To his credit, he has done so. In a highly competitive and shrinking industry, he became a highly regarded engineer working with the Emergency Diesel Generators at Arkansas Nuclear One ("ANO"). Under his tutelage at ANO, the Diesel Generator program was held in high regard among the most reliable B&W Diesel Generators in the fleet for a period of seven years. As a result of his reputation, he was recruited to Davis-Besse in 1999.

Now Mr. Siemaszko has been terminated and appears to have been "blacklisted" from the industry. In spite of his attempts to find work within the industry, every conversation about possible employment has turned into a dead end without explanation.

The financial impacts of termination on Mr. Siemaszko and his family are substantial. He lost a generous salary, excellent health and life insurance benefits, matching retirement contributions, bonuses, paid vacation and other benefits. He was terminated one and a half years short of being vested in the FENOC retirement plan, which would have provided him with a substantial degree of security during his retirement years. As a consequence of his termination, Mr. Siemaszko has had to

borrow substantial money to cover his loan against his 401(k) pension plan, and must pay interest on that loan.

The emotional toll of these events on Mr. Siemaszko and his family cannot be underestimated. The stress and anxiety has impacted every member of the family. Seeing the effect of his termination on his family has exacerbated the emotional impact on him. He has become fearful of his inability to provide support for his family. He has lost the ability to provide them with the stability and security he promised and intended. His children have just adjusted to a new neighborhood and schools following their move to Ohio, and are terrified that they will have to move again. Mr. Siemaszko is deeply troubled that if he can get any work at all, it will be temporary "body shop" work that will take him out of the area, just when his children need an adult male presence. This entire situation has caused tremendous stress on this entire family.

V. CONCLUSION

For the reasons asserted herein, and which will be supplied with greater specificity to the OSHA investigator, Mr. Siemaszko seeks all relief to which he is entitled under the law.

Respectfully submitted,

CLIFFORD, LYONS & GARDE

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